DIVIDE ET IMPERA: PROTECTING THE GROWTH OF HEALTH CARE INCOMES (COSTS)

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It is proper to preamble an essay of this sort with the observation that anyone who has received health care for a serious illness is likely to agree that, with few exceptions, health care sectors in the USA and elsewhere tend to be staffed with millions of smart and highly trained professionals who sincerely seek to improve the quality of their patients' lives. Their admirable clinical efforts, however, are embedded in a ceaseless struggle over money. That struggle is the focus of this essay.

Every health care system naturally pursues two distinct goals, as is illustrated in Figure 1, namely (1) enhancing the quality of patients' lives and (2) enhancing the quality of lives of those who provide real resources to the process of health care (Reinhardt, 1987). Patients also play a dual role in this setting, of course. They are both objects of human compassion and biological structures yielding cash flows, which in the USA can be openly traded on the stock exchanges (Reinhardt, 1999). A strictly observed etiquette in public debates on health policy, however, is never to talk openly about the second goal of health care. Any proposal to enhance the second goal therefore must be styled to seem to further the first goal—e.g. 'enhancing the quality of patient care', 'innovating to create value for patients', 'saving lives', and so on. This essay will stray from that tradition.

Given that every dollar of health care spending is someone's health care income, including fraud, waste, and abuse, there must exist a surreptitious political constituency that promotes at least waste, which many health-policy experts around the world now view as a major ingredient of health spending. The long-standing opposition to cost-effectiveness analysis in the US Congress, for example, can be viewed in part that waste-constituency's work (Carpenter, 2005). That opposition, in turn, can explain why health care spending per capita for statistically similar individuals varies by a factor of 2 to 3 across the USA, and even within one state, and why that variation has been passively countenanced by policy makers, without any sign of curiosity of what added benefits, if any, patients in the high-cost areas receive for the higher spending (see, e.g. New Jersey Commission, 2009a; Dartmouth Atlas of Health Care, 2011).

Policy makers in most other countries have allocated substantial market power to the payment side of health care in Figure 1, including the direct or indirect regulating of prices for health care by government (Marmor *et al.*, 2009). For example, while the Swiss health system is sometimes viewed in the USA as a model for a 'market approach' to health care and of an arrangement that market devotees in the USA call 'consumer-directed health care' (Herzlinger and Parsa-Parsi, 2004), prices and many other facets of the Swiss health system actually are heavily regulated by government (Cheng, 2010), as they are in most other health systems outside the USA.

By contrast, US health policy always carefully and quite deliberately has been aimed at fragmenting the payment side of the health system, to keep it relatively weak vis-a-vis the supply side. For example, during

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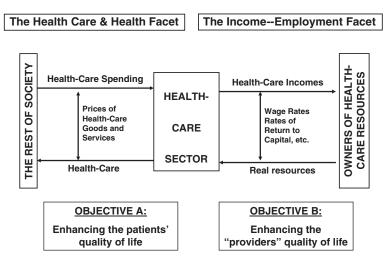


Figure 1. The terrain of the health care battle field

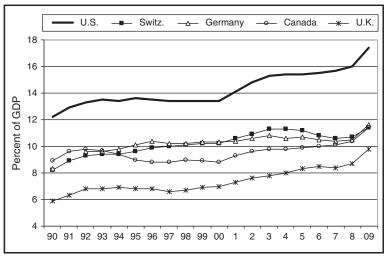
the health reform debate of 2009–2010, Jacob Hacker had proposed to include among the multiple health insurance options to be offered Americans under age 65 at least one government-run health insurance plan, like the federal Medicare program for the elderly. The very idea met with vehement opposition from the supply side of the health care sector during the health reform debate of 2009–2010 (Hacker, 2008) (and, naturally, from the private insurance sector as well). Noting that opposition, President Obama abandoned the idea preemptively in order to curry the providers' support for the rest of his health reform package. The providers' opposition to the 'public option', as it was called, was fueled by fear of a more powerful payment side.

The purpose of this essay is to explore the implications of a relatively weak payment side for the cost of health care in the USA. The thesis is that a fondness among Americans for new high-tech and often high-cost technology, all too often with unproven effectiveness, may be only part of the reason why levels of health spending are so much higher in the USA than elsewhere. More important factors are (1) the huge administrative overhead burdening American health care and (2) the much higher prices that Americans pay for identical health products and procedures (Anderson *et al.*, 2003). These higher prices, as noted earlier, are brought about by public health policies that have kept the payment side of the US health fragmented and weak in the face of the supply side.

1. THE ECONOMIC FOOTPRINTS OF US HEALTH POLICY

Figure 2 illustrates the different economic footprints left behind by these different allocations of market power nations make to the payment and the supply side of the health system. All nations in the OECD, of course, have seen their health sectors absorb ever larger shares of GDP, but none have matched the USA for the sheer size of the bite. According to the latest projection of national health spending published by government actuaries, the USA spent 17.6% of GDP on health care in 2010. It is projected to spend about 20% in 2020 (Keehan *et al.*, 2011). An earlier long-run projection by the Congressional Budget Office, the research arm of the US Congress, had put the percentage at 38% by 2050, if the spending trends of the past four decades continued unabated in the future (Congressional Budget Office, 2007).

Demographic structure cannot explain the much higher health spending in the USA (see Figure 3). On the contrary, the USA, with only 13.3% of its population aged 65 and above in 2009, spent \$8000 in PPP\$ per person (the uppermost point in the graph). By contrast, Germany, Italy, and Japan, with over 20% of their populations aged 65 and above, spent less than half as much (the rightmost three points in the graph).

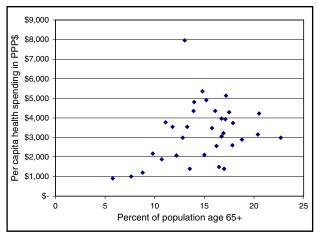


SOURCE: OECD Health Data, various years.

Figure 2. Percentage of GDP claimed by health care, selected countries

In years past, American providers of health care as well as most politicians, business leaders, and the American public had shrugged off these cross-national comparisons with the comforting mantra that 'the American health system is the best in the world, bar none'. In fact, however, a growing body of empirical research in the USA (Commonwealth Fund, 2006; McGlynn *et al.*, 2003) and elsewhere (Pritchard and Wallace, 2011; Banks *et al.*, 2006) has thrown doubt on that proposition. Just recently, for example, the US Business Roundtable released a study, assisted by 12 distinguished health economists, reporting that relative to health spending levels in the rest of the OECD, the USA faces a 24% value gap relative to Canada, Germany, Japan, and the UK (Business Roundtable, 2009).

More ominously, in a recent paper entitled 'How Health Care Can Save or Sink America', Peter R. Orszag has argued no less than that 'the United States' fiscal future depends on whether the country can limit health care costs' (Orszag, 2011). That assessment is not to be taken lightly. Orszag, a distinguished economist, had served in 2007–2008 as director of the Congressional Budget Office, and during 2009–2010 as President Obama's director of the White House Office of Management and Budget (OMB). He bases his dire assessment



SOURCE: OECD Health Data, various years.

Figure 3. Per capita health spending (in PPP\$) and age structure, OECD 2009

on the fact that roughly half of total national health spending in the USA now flows through increasingly constrained federal or state-government budgets. Given the manifest reluctance of Americans to pay added taxes, even for services they actively demand of government, health spending is now pitted against and usually eats into other important priorities in public budgets, such as education, science, and infrastructure.

2. MAJOR DRIVERS OF US HEALTH SPENDING: ADMINISTRATIVE EXPENSES AND PRICES

2.1. Administrative costs of US health care

In 1996, the McKinsey Global Institute issued a report comparing the performance of health systems in the USA, the UK, and Germany in 1990 (McKinsey, 1996). The researchers, guided by four distinguished American economists, tracked in detail the real resources used in treating four standard diseases in 1990. The real-resource use could then be priced out with '1990 US dollars in purchasing power parity (PPP)' to facilitate a decomposition of the treatment cost in one monetary unit. Figure 4 illustrates the decomposition for the USA–Germany comparison.

The McKinsey researchers found that Americans spent significantly more on administrative overhead than did Germans (Figure 4), although less on clinical care proper. In fact, the savings on clinical resources in the USA were almost fully chewed up by higher administrative costs. Probably, the \$259 per capita spending in the category 'Other', which the McKinsey researchers could not identify, included additional administrative expenses as well.

Figure 5 is my amateurish sketch of the so-called 'value chain' in health care (Porter, 1998) in US health care. It highlights the legions of nonclinical enterprises that seek fiscal nourishment in that chain. There are such enterprises in any modern health system, of course. However, in probably few, if any, other country has the health care fray drawn in quite as many camp followers, so to speak, as has US health care.

A typical American academic health center, for example, may deal with several hundreds of different private health insurers, each with their own benefit packages, coverage rules, and fees. It requires literally several hundred billing clerks just for one center, and they all have their counterparts in the insurance industry. As would any hospital, an academic health center also has a sizeable 'compliance staff' charged with keeping the center in compliance with ever more complex government regulations, especially those on billing to public insurance programs. There are outside companies that help physicians bill private or public insurers for services rendered, and that help them to receive maximum payments from these third-party payers. Other niche companies help

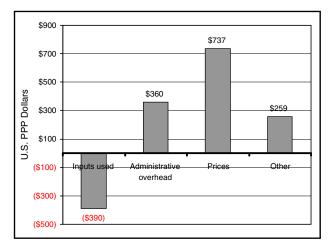


Figure 4. Decomposition of the spending differential USA versus Germany

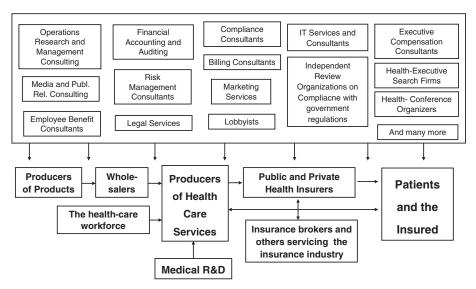


Figure 5. The 'value chain' in US health care

insurers protect themselves from excessively aggressive billing by health care providers. Finally, there are niche firms that help patients with claims processing and argue on patients' behalf with doctors and hospitals over medical bills. I cannot think of any other OECD countries needing such an army of overhead workers just to bill insurers or process claims.

A study by Woolhandler and Himmestein in 2003 had shown a large estimated difference in spending on administration between the US health system and Canada's single-payer system (Woolhandler and Himmelstein, 2003). Commenting critically on that study, Brookings Institution economist Henry Aaron nevertheless opened his critique with this description of the US system:

I look at the US health care system and see an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind-boggling administered prices and other rules expressing distinctions that can only be regarded as weird. (Aaron, 2003)

Unfortunately, the high cost of this 'administrative monstrosity' loads itself fully onto the health care value chain and thus on health spending per capita.

In the above cited McKinsey study, the researchers also found that Americans were estimated to have used far fewer real resources per capita for health care than did Germans in 1990, but they paid much higher prices for these inputs than did Germans. That cost driver has never attracted as much attention in US policy debates as it ought to have received.

2.2. Cross-national comparison of prices

In an article entitled 'US Health Care Costs: The Untold True Story' (Pauly, 1993), Mark Pauly argued that the true cost burden of a nation's health care sector is not properly measured by 'total national health spending' at all, but by the *opportunity cost* of the real resources absorbed by the health care sector. Pauly showed that many nations with much lower health spending per capita than the USA actually appeared to devote significantly more human resources to health care than did the USA. He concluded that 'when politicians and policymakers ask, "How does Germany (or Canada or the United Kingdom) do it?" a large part of the explanation for a lower

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GNP share is that they pay health professionals less—not just physicians, but nurses and technologists, too'. (pp. 32–33).

Lower prices for health care inputs, of course, do not necessarily lead to a smaller supply of real resources for health care, nor to lower quality. Even if they did, that loss would have to be compared with the added quality of life that lower health care prices would bestow on the rest of society—e.g. not crowding out spending on education, science, and infrastructure. Lower prices will, however, detract from the quality of life enjoyed by the providers of health care.

The *International Federation of Health Plans* annually surveys its members in different countries on the prices they pay for a set of standard health care procedures and products (International Federation of Health Plans, 2010). Table I is a summary of these prices for selected procedures or products. Because it is very difficult to obtain accurate and truly comparable data on these prices, one should view individual numbers in the table with some caution. Overall, however, the data do suggest that, on average, Americans pay far more for a given set of real health care resources than is paid for those same resources in other countries.

More recently, in a study reported in Health Affairs, Laugesen and Glied compared the fees paid to physicians for primary care and hip surgery in a number of countries. The authors found that American physicians were paid considerably higher fees not only for hip surgery but also for primary care (Laugesen and Glied, 2011).

It is true, of course, that Americans use some high-tech, high-cost procedures—imaging and cardiac procedures—more frequently than do their counterparts in other countries, which can account for some of the differential in per-capita health spending (Pearson, 2009). But there is little doubt that differential prices across countries for the same service or product play a major part. They are a product of the way in which the health insurance system of the USA is structured.

3. THE US HEALTH INSURANCE SYSTEM

Figure 6 depicts the highly fragmented flow of funds from households, the ultimate payers for all health care, to the providers of health care through various pumping stations along the way, namely the federal government, state governments, employers, and other private payers (e.g. foundations) other than individuals whose out-of-pocket payments flow directly to providers. Not all of the money sucked out of households by these pumping stations flows through to the providers of care. Some of it is retained to cover the cost of administration, marketing, and, in the case of for-profit insurers, profits. Furthermore, not all funds flowing to the providers of health care actually procure inputs for health care proper. As noted earlier, the providers, too, have huge administrative costs coping with the plethora of insurance firms that pay them.

Table I. Cross-national comparison of prices paid by private health plans for selected procedures or products in 2009

					USA		
	Canada	France	Germany	Switzer-land	Low	Average	95th Percentile
CT scan: head	\$65	\$179	\$287	\$360	\$82	\$464	\$1430
MRI scan	\$304	\$398	\$632	\$874	\$509	\$1009	\$2590
Normal delivery ^a	\$2667	\$3768	\$2147	\$3485	\$6379	\$8435	\$13 799
Appendectomy ^a	\$3810	\$2795	\$3285	\$2570	\$7758	\$13 123	\$25 344
Coronary bypass surgery ^a	\$22 212	\$16325	\$27 237	\$11618	\$37 793	\$59 770	\$126 182
Angioplasty	_	\$7666	\$6055	\$5223	\$18 283	\$29 055	\$60 448
Hip replacement ^a	\$10753	\$12 629	\$15 329	\$6683	\$21 247	\$34 454	\$75 369
Nexium	\$32	_	\$136	\$69	\$167	\$186	\$339
Plavix	\$76	\$15	\$99	\$59	\$148	\$152	\$161

^aPhysician and hospital fees combined.

Source: International Federation of Health Plans, 2010 Price Comparisons—Medical and Hospital fees by Country.

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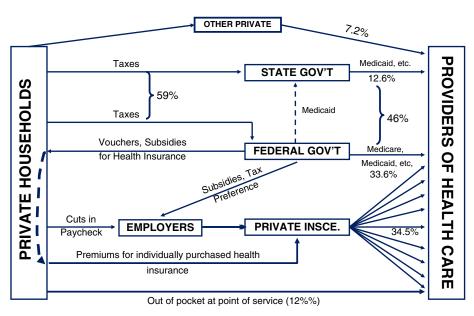


Figure 6. The flow of funds in US health care, 2009

3.1. Public health insurance

About 31% of Americans are covered by public insurance programs, which in 2009 account, however, for 46% of total national health spending because they cover mainly high-cost patients that otherwise could not be served by private insurance without heavy public subsidies.

Roughly half of publicly insured Americans are in the federal Medicare program for the elderly. They have the option of staying within the traditional Medicare program operated by the federal government or choosing coverage by a private *Medicare Advantage* health plan—regular private insurers that also serve employers and the individual market—paid a capitation by Medicare. Roughly 25% of beneficiaries now choose this option (Kaiser Commission, 2010a). Each of the *Medicare Advantage* private plans negotiates fees with individual providers of health care. Providers treating patients in traditional Medicare, on the other hand, are paid on common, national fee schedules whose fees vary only by regional practice costs and some other adjustments. These fees are administered prices set by government. How they are set is explained in easily readable documents accessible to the general public (see, e.g. Medpac, 2010).

Close to 16% of Americans are in the Medicaid program for low-income Americans, the blind, the disabled, and the pauperized Medicare beneficiaries too poor to bear the sizeable out-of-pocket costs Medicare imposes on its beneficiaries. Medicaid is administered by the states, each with its own definition of what constitutes 'low income', although over 60% of its costs are borne by the federal government. These 'threshold incomes', as they are called, vary from a low of 75% of the federal poverty level to 100% and even higher (Kaiser Commission, 2010b). A growing fraction—70% by now—of Medicaid beneficiaries have been contracted out by the states to private managed-care plans that create their own networks of providers with whom to work and with whom they negotiate fees individually (Kaiser Commission, 2010c). The remainder are in state-based programs administered by the states themselves, at fee schedules set by each state.

Unless they are in the field and in military health care, military personnel and their families are covered by the TRICARE program for active military personnel and their families. That program contracts with private insurers to procure health care for the insured and negotiates fees individually with providers of health care. These fees tend to be close to the public Medicare fee levels.

Finally, veterans receive much of their health care from the government-run and government-operated Veterans Administration Health System that operates under a federal budget. It is no small irony, incidentally,

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that so many Americans find 'socialized medicine' abhorrent, all the while reserving for their revered veterans a public program that is the purest form of socialized medicine.

3.2. Private health insurance

Roughly half of America's population of 310 million are covered by private health insurance that is sponsored by an employer and lost when the job is lost. That coverage comes in literally thousands of different versions, each with its own rules. Employers may procure from insurers either full insurance or merely administrative services and then self-insurance. The former procure from competing private insurers group policies that cover all employees and contribute a large fraction (usually between 60% and something short of 100%) to the premium, deducting a pro-rated remainder from the employee's paycheck. Most of the large employers, however, now self-insure, contracting with insurance companies only for claims processing, negotiating prices with providers, and 'managing care', a loose term referring mainly to utilization control, although it could also mean coordinating health care for patients. Until now, only about 5% of Americans under age 65 have procured their insurance coverage in the individual, non-group market. That number, however, is expected to rise significantly when many of the hitherto uninsured will receive federal subsidies too as the result of the *Affordable Care Act* (ACA) of 2010.

Chollet *et al.* (2003) estimated that in 2001, 2151 private insurance companies or insurance plans (e.g. health plans managed by unions for their members) participated in the group policy market, and 643 operated in the individual market. A good many of the latter, of course, are included in the 2151 estimate, as they sell coverage in both markets. There are a few large insurance companies operating nationwide. Although none of them has even a 20% market share of enrollees nationally, they can be highly concentrated regionally (Robinson, 2004), with market shares of the five largest insurers typically well above 60% (AMA, 2007).

As noted above, each individual insurer in the USA must agree somehow on the prices for health care services and products with each individual provider of health care, a process that entails considerable administrative expense. Insurers usually negotiate with hospitals one on one. Even if an insurer has a relatively large market share in a local market, the insurer still may risk losing customers by excluding some hospitals (or entire hospital systems) or large physician groups from the insurer's network or providers. It appears to be the source of the superior bargaining power of providers vis-a-vis private insurers. Moreover, contrary to popular opinion during the health reform debate of 2009–2010, even by President Obama, the more insurers compete in a locality, the weaker each is likely to be (Reinhardt, 2010a).

For physicians, private insurers tend to set fees unilaterally, usually at a fraction X of the Medicare fee schedule, where X is normally larger than 1 but is occasionally smaller than 1. Fees are negotiated with individual physicians or physicians group practices only if the latter object to the size of X. In this market, large multispecialty groups of physicians tend to have a comparative advantage in bargaining over fees. Yet different styles of price negotiations are used for other procedures or health care products.

This approach to pricing health care naturally leads to widespread price discrimination because insurers with a large market share in a local market usually can bargain for lower prices than can insurers with smaller market shares. Furthermore, unless they are very poor and qualify for charity care or steep discounts, uninsured Americans frequently are billed the highest prices and chased for payment by bill collectors, sometimes by methods that would shock citizens of other countries (Missouri School of Journalism, 2011).

Some 16% of the US population, about 50 million Americans, are uninsured at any point in time, although only about half of them for longer periods exceeding 1 year (Congressional Budget Office, 2003). Millions more Americans have shallow insurance that visits large out-of-pocket payments on them when serious illness strikes.

The prices negotiated between private insurers and providers in the USA traditionally have been treated as proprietary trade secrets and generally have not been accessible to researchers or the public. However, a glimpse at the degree of price variation can be had in Tables II and III (New Jersey Commission, 2009b). Table II shows the prices that one large commercial insurer in California pays different hospitals for identical

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Table II. Variation in actual payments made by one large commercial health insurer to different hospitals in California, 2008

	Appendectomy ^a	CABG ^b
Hospital A	\$1800	\$33 000
Hospital B	\$2900	\$54 600
Hospital C	\$4700	\$64 500
Hospital D	\$9500	\$72 300
Hospital E	\$13700	\$99 800

^aActual payment per case (DRG 167).

Source: New Jersey Commission on Rationalizing New Jersey Health Care Resources (2009b), Chapter 6, table 6.5.

procedures. Table III shows the prices one large non-for-profit insurer pays different hospitals and physicians in New Jersey for a colonoscopy. The prices a given hospital or physician receives from different health insurers in New Jersey are likely to significantly vary as well.

More recently, in June 2011, the government of Massachusetts published a report entitled *Price Variations* in Health Care Services (Commonwealth of Massachusetts, 2011). In the executive summary, it is noted that 'prices paid for the same hospital inpatient services and for physician and professional services vary significantly for every service examined. There was at least a three-fold difference for every service and for most, a variation of six- or seven-fold' (p. 2). Wide variations in prices for the same service by private insurers have also been reported for hospitals in Oregon, another one of the very few states that routinely publish such prices (State of Oregon, 2010).

Some American economists consider the price-discriminatory system developed by private health insurers as economically superior to Medicare's cost-based fee schedules. In a recent column published in The Wall Street Journal (Kessler and Taylor, 2011), for example, Stanford University economists Daniel P. Kessler and John B. Taylor assert that the system results 'in better health services for each Medicare dollar because it uses market prices to allocate resources rather than a government determined fee schedule'. I am not aware of any empirical research that would support such a broad assertion. Other opponents of Medicare have belittled the program as a 'dumb price fixer' (Reinhardt, 2003) and a Soviet-style approach to pricing (Antos, 2010). It is no little irony, of course, that Medicare's government-administered prices were imposed on the US health system by none other than President Ronald Reagan, the living icon of market devotees, and his successor, President George H.W. Bush (the Elder) (Reinhardt, 2010b).

I personally find it an intellectual challenge for economists to certify the highly price-discriminatory system begotten by private health insurers in the private market as superior to Medicare's administered prices on grounds of either efficiency or fairness (Reinhardt, 2006). In fact, I agree with the remark on that system by business school professors Michael Porter and Elizabeth Teisberg in their book Redefining Health Care:

'This administrative complexity of dealing with multiple prices [for the same service] adds costs with no benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages individual system participants gain from it, even for those participants who currently enjoy the biggest discounts. The lesson is simple: skewed incentives motivate activities that push costs

Table III. Payments made by one large not-for-profit insurer in New Jersey for colonoscopies performed in hospitals or freestanding ambulatory survey centers (CSAs): minimum and maximum payment per colonoscopy, 2008

	Cost per colonoscopy in network minimum to maximum range		
Actual payment made to:	Minimum	Maximum	
Physicians	\$178	\$431	
Hospitals	\$716	\$3717	
Ambulatory surgery centers	\$443	\$1395	

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^bCoronary bypass with cardiac catheterization (DRG 107); tertiary hospitals only.

higher. All these incentives and distortions reinforce zero-sum competition and work against value creation' (Porter and Teisberg, 2006)

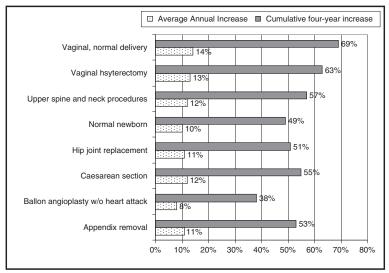
There may have been a time in US history when price discrimination in health care served mainly charitable purposes, to make health care accessible to the poor. Kenneth Arrow thought so in his celebrated paper on US medical care (Arrow, 1963), although earlier Ruben Kessel had argued that profit maximization was the chief motive (Kessel, 1958). Whatever may have been the case half a century ago, however, there can be little doubt that, while a few very poor qualifying patients may receive discounts or free care from hospitals today, the current price-discriminatory system in the USA appears mainly to help the providers of health care maximize their collective monetary claim on GDP. In that regard, the system has been very successful (see Figure 2 above).

4. THE COST-SHIFT THESIS: AN OPEN CONFESSION OF PAYERS' IMPOTENCE

In December of 2010, the American Health Insurance Plans (AHIP), the national association of private health insurers, published an eye-opening report on the actual prices private insurers paid to hospitals in California and Oregon (American Health Insurance Plans, 2010). Figures 7 and 8 are based on the data in that report.

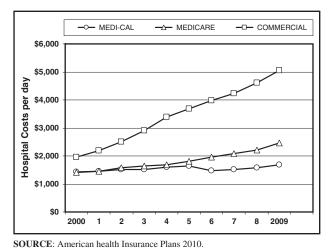
That hospitals in Oregon were able to raise their prices thus in a period when the US economy was sliding into the deepest recession since the Great Depression in the 1930s is astounding and raises the question why private insurers accepted these price hikes. (Reinhardt, 2011b).

One theory is the one advanced in this paper and elsewhere (Reinhardt, 2011b), namely that in most market areas in the USA, private health insurers have relatively less bargaining power than do hospitals or the larger physician groups. The alternative theory, highly popular among insurers, hospitals, and employers, is that government is the culprit behind the high prices paid by private health insurers (Dobson, 2006). This 'cost-shift theory' holds that whenever government insurance programs reduce the 'reimbursement' rates (i.e. prices) they pay the providers of care, hospitals shift any shortfall of public 'reimbursement' from their cost of treating publicly insured patients (Medicare or Medicaid beneficiaries) to private payers who are made to cover the shortfall by being charged higher prices—in effect, that the government is indirectly raising taxes on the private



SOURCE: American Health Insurance Plans 2010; p. 2.

Figure 7. Growth in hospital prices for selected procedures, Oregon, 2005-2009



SOURCE. American health insurance I lans 2010.

Figure 8. Growth in net revenue per hospital admission, California, 2000-2009

sector (Gelfand, 2010). It is assumed to be so even for physicians. Of course, the logical extension of the theory is that large private insurers with more bargaining power also shift costs to smaller insurers with less market clout and to middle-class uninsured Americans who, as noted, often are charged the highest prices.

Most economists are skeptics on the cost-shift theory (Morrissey, 1996; Frakt, 2011) because it rests on two dubious assumptions. First, that there is an *externally* determined correct cost level of health care that the providers cannot help but incur and that must be recovered somehow from payers collectively—hence the word 'reimbursement' rather than just 'payment'. (In America, one pays a hotel or a lawyer, but one 'reimburses' a hospital or a doctor.) Second, the cost-shift theory must mean that in bargaining with insurers over prices, hospitals and other providers charge insurers less than they could and recoup some of that money only when government programs impose price constraints on providers or, one may add, when the medical arms race with competitors causes hospitals to install expensive new medical technology, proven or not. It is a peculiar behavioral theory.

Be that as it may, under either theory, private health insurers are depicted as relatively weak bargainers over prices. That weakness on the payment side offers sobering prospects for the idea to gain better control over the rising cost of health care by relying on legions of competing private health insurers (see also Okma *et al.*, 2011).

5. CONCLUSION: THE POTENTIAL OF AN ALL-PAYER SYSTEM

Whether or not there is validity to the cost-shift theory, the fact that it is widely believed by decision makers in the real world leaves public policy makers in a quandary. If they seek to control spending under Medicare and Medicaid by constraining the prices that these programs pay the providers of health care, they stand accused of shifting costs to private insurers—of taxing the private sector. On the other hand, if they wanted to avoid this alleged cost shift, they would have to adopt some average of the widely varying prices paid by private health insurers. They would then stand accused of letting the Medicare and Medicaid budgets go 'out of control'. It leaves one with the question how else prices might be determined in US health care to have better control over health spending.

One approach would be to operate a single payer system with nationwide, uniform fee schedules, adjusted only for regional variations in input costs—e.g. 'Medicare for all', as this approach is sometimes called in the political arena. Although the state of Vermont recently voted to adopt a single-payer system for that small state (Hsiao, 2011), it can be doubted that this approach would soon be politically feasible in many other US states, if

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ever. Besides, unless subjected to global budgets, single-payer systems have had difficulty controlling the volume of services used, Medicare being a prime example.

A close cousin to a single-payer system would be a multi-payer, all-payer system, such as those operated in the German *Laender* (states) and the Swiss Cantons. The payers could include private managed-care insurance companies with some ability to control utilization. The idea would be that in each state, associations composed of public and private insurers would bargain collectively with relevant associations of providers over common fee schedules, within an overall budget constraint dictated by relevant macroeconomic variables—e.g. growth of GDP or growth of the payroll base—and enforced by government (Reinhardt, 2011b). Such an arrangement has been called a 'quasi market'. In the USA, the state of Maryland has for decades successfully operated an all-payer system, albeit for hospitals only. There prices are not the product of negotiation but set by a well-staffed cost review commission (Maryland Health Services Cost Review Commission, 2011).

Admittedly, a transition from the current to an all-payer system for all providers of health care in all states would be challenging, both analytically and politically. It is a topic in its own right and far too large to discuss in this paper. The challenge undoubtedly will be taken up in the years ahead by US health services researchers among whom the concept of an all-payer system appears to have growing appeal.

The third alternative would be much greater reliance on market forces, which, according to its proponents, 'vest ultimate responsibility for cost containment with individuals and families, who have more limited ability to spend beyond their means than government' (Kessel and Taylor, 2011). This is the economist's delicate way of advocating the rationing of health care substantially by price and the individual's ability to pay, that is, by income class—a straightforward language as yet so politically incorrect in the USA that neither any economist advocating the approach nor any politician would dare use it forthrightly.

A market approach was recently espoused in Republican Congressman Paul Ryan's proposal to convert Medicare into a purely defined contribution program (US House of Representatives, 2011). Government would make a fixed, risk-adjusted, and partially means-tested contribution to that premium, with the average premium contribution growing over time at only the general consumer price index, rather than the average rate of growth of health spending, which traditionally has far outpaced the consumer price index (Reinhardt, 2011a). The Congressional Budget Office has estimated that under this plan, the typical 65-year-old Medicare beneficiary with average health spending would pay out of pocket for premiums, coinsurance, and deductibles a share equal to 68% of total annual health spending on that beneficiary (Congressional Budget Office, 2011).

With the Senate and the White House in the hands of Democrats, the Ryan plan has no chance of being enacted before 2012. The presidential and Congressional election of that year will be a portent of which way the US health system will meander in the decades ahead.

REFERENCES

Aaron HJ. 2003. The cost of health care administration in the United States and Canada—Questionable answers to a questionable question. *The New England Journal of Medicine* **349**: 801–803.

American Health Insurance Plans. December 2010. Recent trends in hospital prices in California and Oregon. Available from: http://www.ahipresearch.org/pdfs/PricesCaliforniaOregon2010.pdf (last viewed August 2011).

American Medical Association. 2007. Competition in health insurance, Table 1: 7–14. Available from: http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf (last viewed August 2011).

Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V. 2003. It's the prices stupid: why the United States is so different from other countries. *Health Affairs* 22: 89–105.

Antos J. October 30, 2010. Confessions of a price controller. *The Journal of the American Enterprise Institute*. Available from: http://www.american.com/archive/2010/october/confessions-of-a-price-controller (last viewed August 2011).

Arrow KJ. 1963. Uncertainty and the welfare economics of medical care. American Economic Review 53: 941-72.

Banks J, Marmot M, Oldfield Z, Smith JP. 2006. Disease and disadvantage in the United States and in England. *Journal of the American Medical Association* **295**: 2037–45.

Business Roundtable. 2009. The Business Roundtable Health Care Value Index[™]. Available from: http://businessroundtable. org/uploads/studies-reports/downloads/The_Business_Roundtable_Health_Care_Value_Index_Executive_Summary.pdf (last viewed August 2011).

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Health Econ. 21: 41-54 (2012)

- Carpenter D. 2005. What politics may be telling us about cost effectiveness analysis. Health Affairs 24: 1174–75.
- Cheng TM. 2010. Understanding the 'Swiss watch' function of Switzerland's health system. Health Affairs 29: 1442–1451.
- Chollet DJ, Smieliauskas F, Konig M. 2003. *Mapping State Health Insurance Markets*, 2001: Structure and Change. Academy for Health Services Research and Health Policy: Washington DC.
- Commonwealth Fund. April 2006. Mirror, Mirror on the Wall: An Update of the Quality of American Health Care through the Patient's Lens. Available from: http://www.commonwealthfund.org/~/media/Files/News/News%20Releases/2006/Apr/New%20Cross%20National%20Comparisons%20of%20Health%20Systems%20%20U%20S%20%20Ranks%20Lowest%20in%20Patient%20Surveys%20%20Has%20Greatest/EMBARGOED_915_Davis_mirror_mirror%20pdf.pdf (last viewed August 2011).
- Commonwealth of Massachusetts. June 2011. Division of Health Care Finance and Policy. Massachusetts Health Care Cost Trends: Price Variation in Health Care Services. Available from: http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/price_variation_report_executive_summary.pdf (last viewed August 2011).
- Congressional Budget Office. May 2003. How Many People Lack Health Insurance and for How Long? Available from: http://www.cbo.gov/ftpdocs/42xx/doc4210/05-12-Uninsured.pdf (last viewed August 2011).
- Congressional Budget Office. November 2007. The Long-Term Outlook for Health Care Spending, Figure 2. Available from: http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf (last viewed August 2011).
- Congressional Budget Office. April 5, 2011. Long-Term Analysis of a Budget Proposal by Chairman Ryan. Available from: http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf (last viewed August 2011).
- Dartmouth Institute for Health Policy & Clinical Practice. 2011. The Dartmouth Atlas of Health Care. Available from: http://www.dartmouthatlas.org/ (last viewed August 2011).
- Dobson A. 2006. The cost-shift payment 'hydraulic': foundation, history, and implications. Health Affairs 25: 22-33.
- Frakt AB. 2011. How much do hospitals cost shift? A review of the evidence. *The Milbank Quarterly* **89**: 90–130. Available from: http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00621.x/full (last viewed August 2011).
- Gelfand JP. June 14, 2010. Small business in for rough ride. *National Journal*. Available from: http://healthcare.national-journal.com/2010/06/the-smallbusiness-reality.php#1593102 (last viewed August 2011).
- Hacker JS. December 2008. The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage. New America Foundation. Available from: http://institute.ourfuture.org/files/Jacob_Hacker_Public_Plan_Choice.pdf (last viewed August 2011).
- Herzlinger RE, Parsa-Parsi R. 2004. Consumer-driven health care: lessons from Swizterland. *Journal of the American Medical Association* **292**: 1213–20.
- Hsiao WC. 2011. State-based single payer health care—a solution for the United States? *The New England Journal of Medicine* **364**: 1188–90.
- International Federation of Health Plans. 2010. Comparative Price Report—Medical and Hospital Fees by Country. Available from: http://www.ifhp.com/documents/IFHPPricereportfinal.pdf (last viewed August 2011).
- Kaiser Commission on Medicaid and the Uninsured. 2010a. Medicare Advantage Fact Sheet. September 2010. Available from: http://www.kff.org/medicare/upload/2052-14.pdf (last viewed August 2011).
- Kaiser Commission on Medicaid and the Uninsured. 2010b. Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities. February 2010. Available from: http://www.kff.org/medicaid/upload/8046.pdf (last viewed August 2011).
- Kaiser Commission on Medicaid and the Uninsured. 2010c. Medicaid and Managed Care: Key Data, trends and Issues. February 2010. Available from: http://www.kff.org/medicaid/upload/8048.pdf (last viewed August 2011).
- Keehan SP et al. 2011. national health spending projections through 2020: economic recovery and reform drive faster spending growth. *Health Affairs* **30**: 1594–1605.
- Kessel RA. 1958. Price discrimination in medicine. Journal of Law and Economics 1: 20-53.
- Kessler DP, Taylor JB. August 17, 2011. Medicare reform: Obama vs Ryan. The Wall Street Journal p. A15.
- Laugesen MJ, Glied SA. September 2011. Higher fees paid to U.S. physicians drive higher spending for physician services compared to other countries. *Health Affairs* **30**(9): 1647–56.
- Marmor TR, Oberlander J, White J. 2009. The Obama administration's options for health care cost control: hope versus reality. *Annals of Internal Medicine* **150**: 485–9.
- McGlynn EA et al. 2003. The quality of health care delivered to adults in the United States. *The New England Journal of Medicine* **348**: 2635–45.
- McKinsey Global Institute. October 1996. Health Care Productivity.
- Medicare Payment Advisory Commission (Medpac). October 21, 2010. Physician Services Payment System. Available from: http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_Physician.pdf (last viewed August 2011) and *Hospital Acute Inpatient Services Payment System*. October 2010. Available from: http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_hospital.pdf (last viewed August 2011).
- Missouri School of Journalism. 2011. Missouri Lifetime Journalism Award: Wall Street Journal. Available from: http://www.journalism.missouri.edu/lifestyle/medical-insurance.html (last viewed August 2011).

Copyright © 2011 John Wiley & Sons, Ltd.

Health Econ. 21: 41–54 (2012)

- Morrissey M. December 1996. Hospital cost shifting, a continuing debate. *Employee Benefit Research Institute Issue Brief* 180, p.12.
- New Jersey Commission on Rationalizing Health Care Resources. 2009a. Final Report, Table 6.1, p. 87. Available from: http://www.nj.gov/health/rhc/reports.shtml (last viewed August 2011).
- New Jersey Commission on Rationalizing Health Care Resources. January 2009b. Final Report, Chapter 6, Tables 6.2 and 6.4. Available from: http://www.nj.gov/health/rhc/finalreport/documents/entire_finalreport.pdf (last viewed August 2011).
- Okma KGH, Marmor TR, Oberlander J. 2011. Managed competition for Medicare? Sobering lessons from the Netherlands. *The New England Journal of Medicine* **365**: 287–9.
- Orszag PR. 2011. How health care can save or sink America. Foreign Affairs 90: 42-56.
- Pauly MV. 1993. U.S. health care costs: the untold true story. *Health Affairs* 12: 152–9.
- Pearson M. September 30, 2009. Disparities in health expenditures across OECD countries: why does the United States spend so much more than other countries? Written Statement for the U.S. Senate Special Committee on Aging. Organization for Economic Co-Operation and Development (OECD). Available from: http://www.oecd.org/dataoecd/5/34/43800977.pdf (last viewed August 2011).
- Porter ME. 1998. Competitive advantage: creating and sustaining superior performance. Available from: http://www.google.com/search?q=Value+chain&hl=en&rlz=1R2GGHP_enUS366&biw=1024&bih=591&prmd=ivnsb&tb-bm=isch&tbo=u&source=univ&sa=X&ei=raFOTtDMIcHu0gHhyemVBw&sqi=2&ved=0CDUQsAQ (last viewed August 2011).
- Porter ME, Teisberg EO. 2006. Redefining Health Care. Harvard Business School Press: Boston MA; 65-6.
- Pritchard C, Wallace MS. 2011. Comparing the USA, UK and 17 Western countries' efficiency and effectiveness in reducing mortality. *Journal of the Royal Society of Medicine* Short Reports 2: 1–10.
- Reinhardt UE. 1987. Resource Allocation in health Care: The Allocation of Lifestyles to Providers. The Milbank Quarterly 65: 153–76 and Reinhardt UE. 1982. Table Manners at the Health Care Feast: Regulation vs Market. In Financing Health Care: Competition versus Regulation, Yaggy D, Anlyan WG (eds.) Ballinger Publishing Company: Cambridge, MA: 13–33.
- Reinhardt UE. 1999. Do you sincerely want to be rich? *Health Economics* 8: 355–62.
- Reinhardt UE. 2003. The Medicare World from Both Sides: A Conversation with Tom Scully. *Health Affairs* 22: 167–74.
- Reinhardt UE. 2006. The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy. Health Affairs 25: 57–69.
- Reinhardt UE. July 9, 2010a. Will More Insurers Control health Spending Better? Health Affairs Blog. Available from: http://healthaffairs.org/blog/2010/07/09/will-more-insurers-control-health-care-costs-better/ (last viewed August 2011).
- Reinhardt UE. November 12, 2010b. Medicare's Soviet Label. The New York Times Economix. Available from: http://economix.blogs.nytimes.com/2010/11/12/medicares-soviet-label/ (last viewed August 2011).
- Reinhardt UE. April 2011a. Comparing Medicare's Plan to What Congress Gets. The New York Times Economix Blog. Available from: http://economix.blogs.nytimes.com/2011/04/18/comparing-ryans-medicare-plan-to-what-congress-gets/ (last viewed August 2011).
- Reinhardt UE. November 2011b. The many different prices paid to providers and the flawed theory of cost-shifting: is it time for a more rational all-payer system? Commentary forthcoming in *Health Affairs*.
- Robinson JC. 2004. Consolidation and the transformation of competition in health insurance. *Health Affairs* 23: 11–24.
- State of Oregon. 2010. Compare Hospital Prices. Available from: http://www.oregon.gov/OHA/OHPR/RSCH/comparehospitalcosts.shtml (last viewed August 2011).
- The Maryland Health Services Cost Review Commission. 2011. Main Website. Available from: http://www.hscrc.state.md. us/ (last viewed August 2011).
- U.S. House of Representatives. 2011. House Committee on Budget. The Path to Prosperity: Fiscal Year 2012 Budget Resolution. Available from: http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf (last viewed August 2011).
- Woolhandler S, Himmelstein DU. 2003. Costs of Health Care Administration in the United States and Canada. *The New England Journal of Medicine* **349**: 768–775.

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